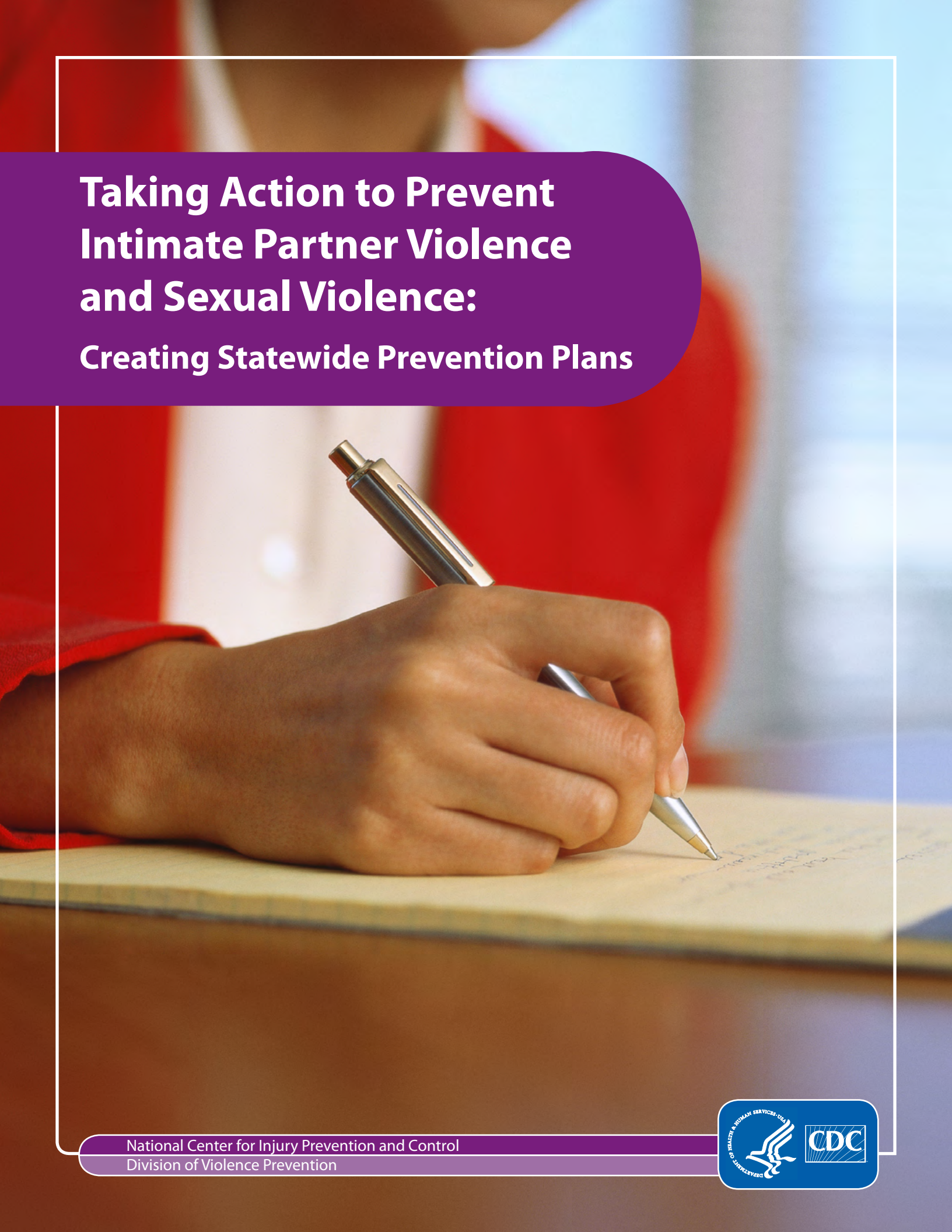
Taking Action to Prevent Intimate Partner Violence and Sexual Violence:

Creating Statewide Prevention Plans



National Center for Injury Prevention and Control
Division of Violence Prevention

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Background

Intimate partner violence (IPV) and sexual violence (SV) are significant public health problems that negatively impact physical and emotional health and have serious consequences for victims, families, and communities. According to 2010 findings from the National Intimate Partner and Sexual Violence Survey (NISVS)[1], about 1 in 4 women (24.3%) and 1 in 7 men (13.8%) in the U.S. have experienced severe physical violence by an intimate partner (e.g., hit with a fist or something hard, beaten, slammed against something) at some point in their lifetime. Additionally, nearly 1 in 5 women and 1 in 71 men have been raped in their lifetime.

As part of their efforts to address these two significant public health problems, the Centers for Disease Control and Prevention (CDC) funds state-level organizations for the prevention of the initial occurrence (primary prevention) of IPV and SV. Primary prevention requires comprehensive, coordinated, and sustained efforts of multiple, diverse organizations and stakeholders. These organizations and stakeholders further require both general and primary prevention specific organizational capacity to successfully adopt, implement, evaluate, and sustain primary prevention principles, concepts, and practices.[2,3]

With these requirements in mind, CDC developed two programs. The Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program funds State Domestic Violence Coalitions (SDVCs) for the primary prevention of IPV. The Enhancing and Making Programs and Outcomes Work to End Rape (EMPOWER) program provided additional funding, technical assistance and training to a subset of the national Rape Prevention Education (RPE) program grantees. RPE grantees are state health departments funded for the primary prevention of SV.

To build prevention and evaluation capacity while developing state primary prevention plans, both the DELTA and EMPOWER programs required each grantee to hire an Empowerment Evaluator (EE). The EE facilitated a learning-by-doing process based on the 10 empowerment evaluation principles: community ownership, inclusion, democratic participation, community knowledge, evidence-based strategies, accountability, improvement, organizational learning, social justice and capacity building.[4]

DELTA

While a grassroots movement has been working for over three decades to end IPV, the traditional focus of these efforts has been on the provision of services to victims after the violence occurred. The Family Violence Prevention and Services Act (FVPSA) authorizes CDC to distribute federal funds to support coordinated community responses (CCRs) that address IPV. A CCR is an organized effort to prevent and respond to IPV in a community. It typically coordinates the work of diverse service sectors, such as organizations involved in victim services, law enforcement, prosecution, public health, and faith-based initiatives. Historically, CCRs have focused on providing services to victims, holding perpetrators accountable, and reducing the number of recurring assaults.

In 2002, CDC used FVPSA funding to develop the DELTA Program, focusing on the primary prevention of IPV at the community level. From 2002 to 2013, DELTA funded 14 SDVCs to provide primary prevention-focused training, technical assistance, and financial support to local CCRs. Local CCRs then developed and implemented strategies focused on preventing first-time perpetration and victimization. The 14 SDVCs were located in Alaska, California, Delaware, Florida, Kansas, Michigan, Montana, New York, North Carolina, North Dakota, Ohio, Rhode Island, Virginia and Wisconsin. At the time of analysis (December 2010), the 14 DELTA Program SDVCs supported 59 local CCRs with primary prevention focused funding, training, and technical assistance.

CDC recognized that the long-term sustainability and expansion of IPV primary prevention work within each DELTA-funded state and within each DELTA-supported CCR would require broader fiscal and programmatic support beyond what each DELTA SDVC could provide. Hence, in the 2005 DELTA Program funding announcement, CDC required DELTA Program grantees to develop a data-driven, state-level IPV Prevention Plan with a diverse group of stakeholders acting as the state steering committee. Through the development of the state prevention plan, it was hoped that state-level partnerships that understood and supported primary prevention work would be established within each DELTA state.

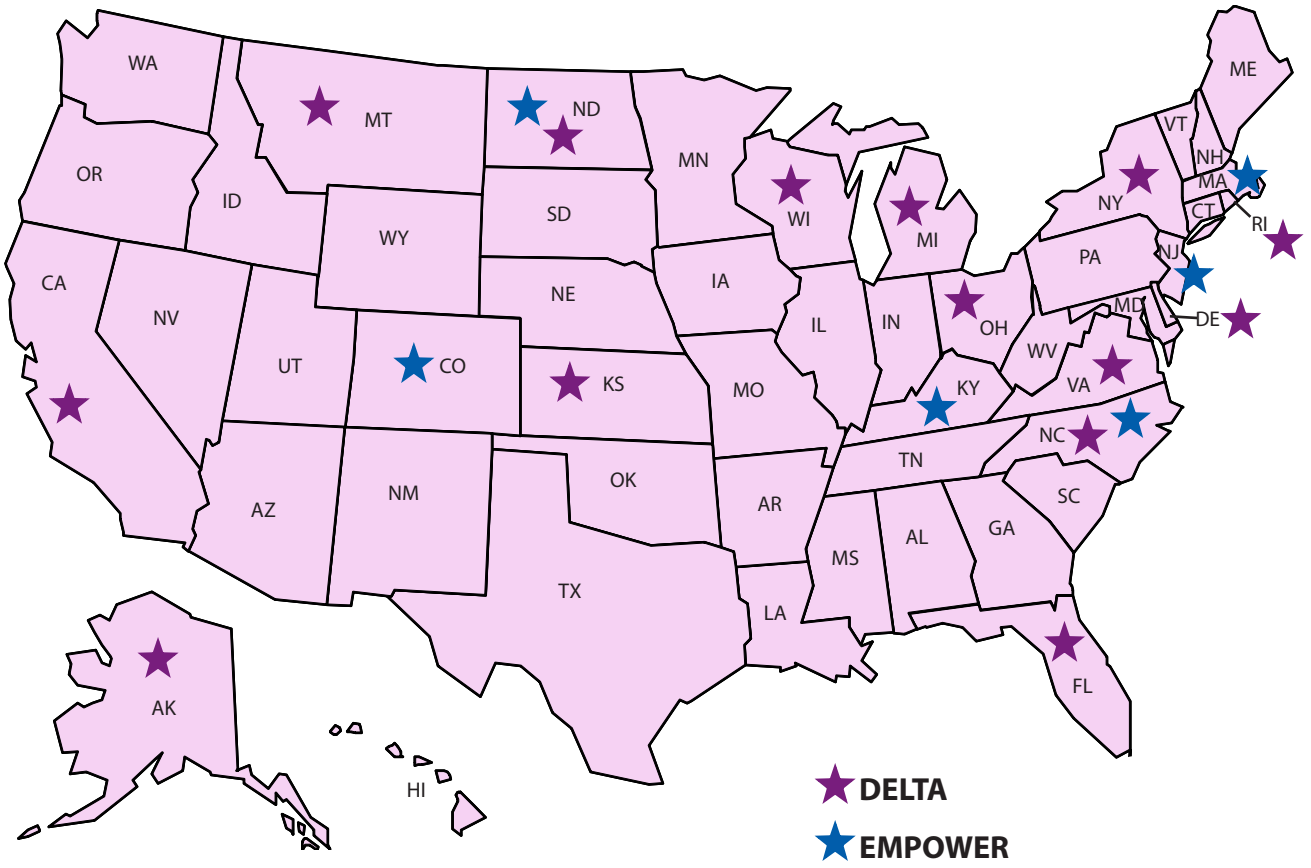
EMPOWER

A grassroots movement also has been working for over three decades to end SV, and as with IPV, the historical focus has been on the provision of services to victims. In 1994, as a component of the Violence Against Women Act (VAWA), the RPE Program was established at CDC. The RPE Program is intended to promote the prevention of sexual violence in all 50 states, the District of Columbia, Puerto Rico, and six U.S. territories. In 2005, CDC made substantial changes to the RPE Program, adding social change elements and emphasizing primary prevention of sexual violence. RPE grantees are state health departments and are strongly encouraged to work closely with their state sexual violence coalitions. RPE grantees are expected to implement comprehensive, multi-faceted programs that address multiple levels of the social ecology and adhere to the public health model.[5] To support these changes, CDC increased efforts to build the primary prevention capacity of RPE grantees and the larger prevention system.[6,7]

Given the importance of understanding the opportunities, challenges, and needs in building the primary prevention capacity of RPE grantees, CDC launched the EMPOWER Program in 2005 as a capacity building demonstration project. The purpose of EMPOWER was "to build comprehensive prevention program planning and evaluation capacity among selected Rape Prevention and Education (RPE) funded sexual violence prevention programs and to assess short-term and intermediate capacity building outcomes for each program."[8] The EMPOWER Program provided additional funding, technical assistance, and training to a subset of RPE grantees. Six states, Colorado, Kentucky, Massachusetts, New Jersey, North Carolina, and North Dakota, were selected through a competitive request for applications.[7]

EMPOWER Program grantees were required to convene a diverse state planning committee, called the state prevention team, to develop a comprehensive state plan for sexual violence prevention programming and evaluation, contract with an in-state evaluator to support planning efforts, and develop a state capacity building team that included, at minimum, the evaluator, the state EMPOWER coordinator and another member of the state prevention team.[7]

Location of DELTA and EMPOWER States



Method

State plan documents were submitted to CDC by each of the six states participating in the EMPOWER Program and each of the fourteen states participating in the DELTA Program. In total there were nineteen plans, because North Dakota (a DELTA & EMPOWER grantee) submitted a joint state prevention plan for IPV and SV. While the analyses of the plans from DELTA and EMPOWER programs were conducted separately, parallel methods were followed. For each program (i.e. DELTA and EMPOWER), open coding of two state plan documents was initially conducted by a team of coders. Coding categories were then refined for each program and further limited to address specific themes of interest to CDC. All of the state plans within each program were then coded based on the revised coding scheme, each by a minimum of two coders. A summary report was developed for each state based on themes identified in the coding. The findings from the coding of the state plans from both programs, the state summary reports, and an additional review of the original state plan documents were then combined to develop a set of meta-themes based on common successes and challenges.

Successes

Across the DELTA and EMPOWER state plans for IPV and/or SV, a number of promising findings emerged. Overall, the state plans demonstrated grantees' knowledge and skills for planning, implementation and evaluation utilizing public health principles, processes and concepts. For both the DELTA and EMPOWER programs, the state plans represent a significant departure from previous planning efforts or were a new endeavor in their own right. The following meta-themes that emerged from the plan analyses further illustrate this.

Use of Data and Evidence to Inform Primary Prevention Planning

DELTA and EMPOWER grantees developed state plans using many sources and types of data, with attention to identifying strategies based on the best available research evidence and focusing on approaches intended to prevent the initial occurrence of IPV and SV. In many cases, the plans demonstrate a shifting of attention to perpetration as reflected in identification of a lack of data on perpetration-related risk factors, the identification of selected populations at greater risk for perpetration, and the selection of strategies focused specifically on primary prevention of perpetration (rather than general awareness, risk reduction, victimization response and other types of secondary and tertiary prevention). Most plans include an examination of state-specific contextual issues and the inclusion of preliminary evaluation concepts. The plans also document numerous points in the planning process that required new information and data for the state.

•North Dakota EMPOWER and DELTA Program

Often, in conducting a needs and resource assessment, planning committees end up focusing more on needs than resources. In an effort to ensure that this did not happen in North Dakota, the state capacity building team conducted an extensive process for asset mapping. Working with the Resource Subgroup of the state prevention team, the state capacity building team identified numerous local and state level resources for IPV and SV prevention. Resources fell into six categories: community organizations, youth organizations, law and legal enforcement, school-based resources, data sources, and medical resources. Each of the categories was then subdivided into state, tribal, county and local resources. Once the resources were identified, a detailed eco-map was constructed and potential links with each of the categories were articulated. For example, in reviewing school-based resources, the state prevention team noted that schools provide an excellent venue for conducting prevention programming and often have existing violence prevention programs, providing a natural opportunity to build partnerships. By using community and demographic data to identify places of shared interest and opportunities for collaboration, the North Dakota IPV and SV prevention team was able to keep these considerations at the forefront as they developed the state plan.

•Rhode Island DELTA Program

In order to ensure that the planning process was data-driven, the Rhode Island IPV prevention plan draws on demographic and community data. Several statewide surveys, including the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavioral Survey (YRBS), and several school-based assessments, were used to attempt to identify state-specific risk factors to inform plan development. A prevention system capacity assessment[1] was conducted to identify strengths and challenges and to drive goal development for increasing prevention system capacity. As a result, DELTA Program participation has led to the development of the state's first data-driven plan to prevent first-time perpetration of IPV, including elements designed to promote sustainability and problem-solving capacity development.

•Massachusetts EMPOWER Program

Although EMPOWER grantees were tasked with engaging in a data-informed planning process, the lack of state-specific data relevant to sexual violence primary prevention was a universal challenge. The Massachusetts state prevention team in conducting their needs and resource assessment faced a number of challenges. Some areas of archival data did not exist. In other cases, while the data existed, key subpopulations were not included so the data could not be broken down to assist in identifying selected populations. Additionally, most archival data had significant limitations, making it difficult to create a comprehensive picture of sexual violence in Massachusetts. Despite these difficulties, the state prevention team was creative and persistent. In developing their state profile, the prevention team inserted "placeholders" where data for a particular subpopulation was missing. For example, in reporting on the gender distribution for the state, no information was available for transgender populations. The planning team inserted this category and listed the data as missing, thus drawing attention to areas for improved data collection. Additionally, as the prevention team identified other gaps in the data, they sought to collect new data when possible. For example, since no data sources existed regarding resources for sexual violence prevention, the state prevention team surveyed professionals and community members. While the state prevention team was not able to address all of the data limitations, they were still able to engage in a data-driven planning process, creating goals and outcomes tied to identified needs and resources within the state.

•North Carolina DELTA Program

The lack of evidence-based programs specific to IPV primary prevention created a challenge for evidence-based planning. To support the state steering committee's work in North Carolina, the state Project Coordinator and evaluation team developed a catalog of evidence-based programs, drawing from other fields. Beginning with an extensive review of the published literature and program registries, the group identified programs that might have relevance for preventing IPV based on shared risk and protective factors, outcomes that decreased IPV-related risks, and outcomes that increased positive change related to IPV prevention. The list of potential programs for inclusion was further narrowed based on considerations such as the extent to which the program had been evaluated, the public availability of the program, and other factors. Programs in the catalog were then organized around the characteristics of the program, setting, evaluation outcomes, implementation characteristics, level of the social ecology, life stage and relevancy to plan goals, with a summary of each program provided. To further support the steering committee in selecting programs from the catalog, the evaluation team and Project Coordinator also introduced and expanded the selection criteria to include more applied considerations, such as cost, sustainability, transferability and adaptability. The resulting state plan incorporated a high degree of evidence-based decision-making and resulted in a tool to support evidence-based program selection for communities across the state.

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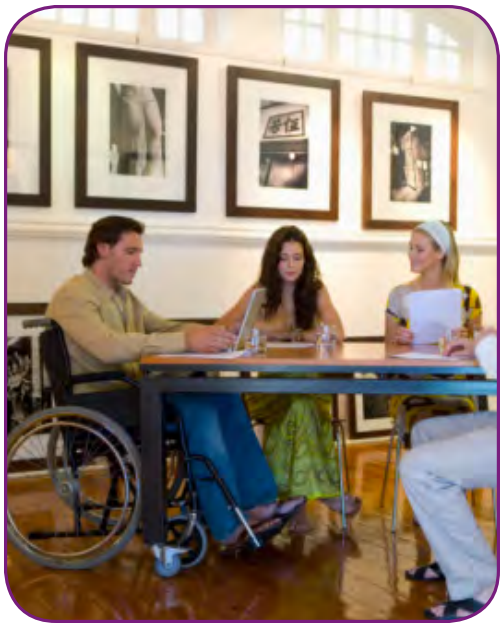
[1] Prevention system capacity is defined as a network of individuals, groups, and/or organizations that, through their interaction, works to address and prevent a public health problem. The system consists of the following dimensions: overall system profile, leadership, strategic planning, information, community/constituency focus, human resources, system operations and documented results/outcomes. A prevention system capacity assessment tool was developed by the CDC and EMPOWER grantees and shared with both EMPOWER and DELTA grantees.

Prioritization of the Need to Improve Prevention System Capacity for IPV and SV Primary Prevention



The EMPOWER grantees, in collaboration with CDC, developed and used a tool for assessing prevention system capacity. Some of the DELTA grantees used the same tool as is, some of them modified the tool, and some of them developed their own tool. Both EMPOWER and DELTA grantees identified a number of areas for improvement, so state prevention teams/steering committees often developed state-specific criteria for prioritizing system development. For example, almost all states included plan goals intended to improve existing data to inform SV and IPV primary prevention efforts since improved data was seen as critical to effective prevention planning. This prioritization reflects both recognition of the importance of data-driven prevention efforts and commitment to improving prevention system capacity. According to the Interactive Systems Framework for Dissemination and Implementation there is a link between prevention system capacity and successful primary prevention efforts. Hence, the increased attention to prevention system capacity among grantees suggests potential improvements in SV and IPV primary prevention efforts over time.

•Delaware DELTA Program

Completing thorough assessments of needs and resources and prevention system capacity highlighted the centrality of the prevention system for the Delaware state steering committee. After identifying initial areas for potential plan inclusion, a pathway map was created, illustrating that enhancing the prevention system was foundational to the expansion of IPV primary prevention work. As a result, the majority of plan goals and objectives focus on increasing prevention system capacity and these goals precede goals related to addressing the needs of specific groups or populations. For example, the state plan includes a goal focused on improving data systems, with activities and strategies such as promoting new research for IPV primary prevention, encouraging innovation in data dissemination, supporting program evaluation technical assistance and others. Improvements in data collection and dissemination address several dimensions of prevention system capacity, including strategic planning, information, community and constituency focus and results and outcomes. In attempting to increase and improve human resources within the prevention system, the plan includes strategies for engaging and building IPV prevention capacity among non-traditional partners and school systems. Accomplishing these strategies includes activities such as training and technical assistance, as well as advocacy for organizational changes that support workers in integrating IPV primary prevention in existing work.

•Michigan DELTA Program

As part of their data-driven, comprehensive planning processes, each of the DELTA states included an assessment of prevention system capacity. In Michigan, as in many of the DELTA states, the state steering committee identified several dimensions of prevention system capacity that were in need of attention but chose to prioritize those that most directly supported local IPV prevention efforts. These dimensions consist of: constituency and community focus, human resources, and system operations. Thus, the plan includes an ongoing process to identify local community needs (community and constituency focus), ways to build the knowledge and skills of local communities for primary prevention (human resources), and developing support mechanisms and accessible materials for local communities undertaking IPV primary prevention efforts (system operations).

•Kentucky EMPOWER Program

In developing a state sexual violence prevention plan, an important consideration is the capacity of those who will be responsible for implementing programming. In Kentucky, the primary responsibility for implementation fell to the local rape crisis centers. To inform the planning process regarding this key area, a survey was administered to the executive directors and rape prevention educators at local rape crisis centers. In assessing individual prevention capacity, the survey asked about experiences, knowledge and attitudes in six areas: program planning, implementation and evaluation concepts, principles of primary prevention, collaboration with partners, resources or barriers, and knowledge of sexual violence. One of the findings that emerged from the data was that survey participants lacked a shared understanding of primary prevention of sexual violence. To help address this and other resource limitations for local implementers, the state prevention team adopted a single, more structured program to be used by all of the rape crisis centers in their sexual violence prevention work. Implementation plans were also developed to include additional trainings and ongoing technical assistance.

Expansion of Partnerships and Increased Ownership among Diverse Constituencies for SV and IPV Prevention.

EMPOWER and DELTA plans reflect a rich diversity of planning committee participants, often extending beyond existing relationships. Diversity considerations included a broad array of dimensions, such as ethnicity, race, gender, sexual orientation, sector, geography and differing abilities. For many states, the planning process brought partners from areas such as education, tribes, local sexual and domestic violence programs, social service agencies, disability rights organizations, and other non-traditional partners together to inform the planning process and to expand potential resources for SV and IPV primary prevention. The diversity of prevention team/steering committee participants was the result of intentional efforts on the part of grantees. Throughout the recruitment, formation, and planning phases, key stakeholders involved in developing the plan continually engaged in intentional reviews of membership and recruited additional members as gaps were identified or as membership shifted over time. The engagement of new partners was further supported through the development of inclusive planning processes to encourage shared ownership in the plan.

•California DELTA Program

California's state planning process highlighted the need for increased funding to support IPV primary prevention efforts. While finding additional money for primary prevention efforts in the current economic climate will not be easy for any of the states, California's DELTA Program is leveraging relationships to increase their likelihood of success. California has a significant history in the area of primary prevention of violence against women as several national technical assistance providers, such as Transforming Communities, Futures Without Violence (formerly the Family Violence Prevention Fund), the Prevention Institute, and Prevent-Connect (housed within the state sexual violence coalition), are based in California, and the state has a well-funded RPE Program. Participating in the DELTA Program and the state IPV prevention planning process have led to recognition of the state domestic violence coalition, the California Partnership to End Domestic Violence, as an organization that can play a meaningful role at the state level in promoting primary prevention. As a result, a new partnership, called the California Violence Against Women Primary Prevention Partnership (which includes the state health department, the state domestic violence coalition and the state sexual violence coalition), was created to "launch a cohesive effort to develop new and sustained state-level funding specifically for the primary prevention of violence against women."

•New Jersey EMPOWER Program

To build ownership in the state sexual violence prevention plan, the New Jersey state capacity building team sought to engage stakeholders in an inclusive planning process from the start. A wide variety of stakeholders were recruited for the prevention team with the intention of building new partnerships to support sexual violence prevention efforts. A consensus-based decision-making model was used to ensure that all voices were equally valued. While smaller workgroups were often convened to complete work on a particular aspect of plan development, all final decisions regarding the plan were made by the full prevention team. Local RPE Program grantees were included during the identification of strategies and programs to ensure that decisions reflected the experiences of frontline staff. Committee members often met several times a month, either by phone or in-person, to conduct planning work. When maintaining such a high level of prevention team participation became challenging during some of the more complex aspects of the planning process, members of the state capacity building team personally contacted prevention team members to encourage them to keep participating. Although ensuring that an inclusive planning process occurred was labor-intensive for the state capacity building team, the end result was a sexual violence prevention plan with a high level of ownership across a number of stakeholders.

•Kansas DELTA Program

While the Kansas Department of Health and Environment and the Kansas Coalition Against Sexual and Domestic Violence have collaborated for many years and on many projects, the development of a joint state plan for SV and IPV primary prevention required a new depth of collaboration. Prior to 2005, both the DELTA Program (administered by the state domestic violence coalition) and the Rape Prevention and Education Program (RPE) (administered by the state health department) had advisory councils but little planning had been conducted by either group. While a representative of each organization served on each of the councils, the state health department was solely responsible for administering the RPE Program and the SDVC was solely responsible for the DELTA Program. The requirement for both projects to engage in state-level planning spurred the development of a stronger partnership between the two entities to develop a joint plan for the primary prevention of SV and IPV in Kansas. The collaboration between the state department of health and the state domestic violence coalition regarding SV and IPV primary prevention expanded available resources for the planning process. For example, each of the organizations was able to bring different stakeholders to the planning process. Additionally, the Kansas DELTA evaluation team was able to provide supports (such as analytical skills and the Empowerment Evaluator) for the planning process while the Kansas Sexual Violence Prevention and Education Program harnessed the data collection capabilities of the state health department. The partnership developed through the state planning process has continued to grow, influencing capacity development in local communities through such activities as the development of a joint community of practice that includes local communities funded for IPV and SV primary prevention efforts. Because many of the activities within the state plan have been assigned to the state department of health and the state domestic violence coalition jointly, this collaboration continues to grow. The two organizations are working to institutionalize this collaboration.

•Ohio DELTA Program

Too often, the responsibility for preventing IPV is seen as the job of a particular organization or agency, most often those agencies or organizations aligned with the battered women's movement. The needs for social change for effective IPV prevention and resource limitations require that a broad array of individuals, organizations and sectors take ownership of their role in ending IPV. To build ownership in the development and implementation of the state IPV prevention plan, Ohio sought to engage stakeholders in an inclusive planning process from the start. A wide variety of stakeholders were recruited for the state steering committee with the intention of building new partnerships to support IPV prevention efforts. The state Prevention Coordinator and Empowerment Evaluator were intentional in designing group processes to promote active participation by committee members and to address planning issues as they arose. Ohio adapted and simplified planning steps while still conducting a data-driven, evidence-informed planning

process, incorporating a consensus-based decision-making model to ensure that all voices were equally valued. While smaller workgroups were sometimes convened to complete discrete tasks, all final decisions were made by the full steering committee. A collaboration charter, a formalized document developed by the collective group, articulating expectations of how the group would work together, was used to assist in maintaining continuity when steering committee turnover occurred. Several state steering committee members from Ohio expressly commented on the excellent facilitation of the planning process. Although ensuring an inclusive planning process was labor-intensive, it resulted in an IPV prevention plan with ownership across a wide range of stakeholders.

Commitment of State Prevention Teams/State Steering Committees to Ongoing Planning and Improvement for IPV and SV Primary Prevention

Both EMPOWER and DELTA plans demonstrate a commitment to ongoing planning and improvement in a number of ways. One reflection of this commitment can be seen in the prevention system capacity assessments and the associated plan goals. All grantees engaged in a prevention system capacity assessment, evaluating strengths and challenges and developing goal(s) for improving system capacity. In most cases, members of the state prevention teams/state steering committees represented key components of the state prevention system. Committee members supported enhancing system capacity in several sectors, including their own. An additional reflection of increased commitment to ongoing planning and improvement is evident in prevention team/steering committee structure. In several states, the prevention team/steering committee was formed as a subcommittee of an existing state committee or task force. In other states planning duties were added to the function of an existing committee or taskforce, some of which report directly to the governor or other high ranking government official. This institutionalized the ongoing responsibility for planning, implementation, evaluation and continuous quality improvement. In most states, the prevention team/steering committee included high-level representatives of key state institutions.

•Wisconsin DELTA Program

DELTA Program states used a variety of approaches in developing a state steering committee. For many states, this required the creation of an entirely new entity. In Wisconsin, however, the DELTA Program took advantage of existing structures to promote the integration of IPV prevention efforts within larger efforts to address IPV. The state steering committee was created through the addition of an ad-hoc subcommittee to the Governor's Council on Domestic Abuse. The Governor's Council on Domestic Abuse is a statutorily created, 13 member body that advises the governor, legislature, and Department of Children and Families on domestic abuse issues. This group includes representatives from numerous sectors with expertise with domestic violence, prevention, state agencies and culturally specific statewide organizations. Operating under the auspices of the Governor's Council helped to add credibility to the work of the group, ensure recognition of IPV prevention efforts by governmental bodies, and institutionalize IPV primary prevention planning, implementation and evaluation efforts. Moving forward, the subcommittee will remain a permanent structure within the larger Council and has committed to implementing the plan, evaluating its effectiveness, and engaging in ongoing improvement.

•New York DELTA Program

The New York DELTA Program assessed the capacity (including knowledge, skills and motivation) of the steering committee itself to drive state-level capacity building efforts. The state Project Coordinator and Empowerment Evaluator used a modified version of the prevention system capacity assessment tool to assess both the prevention system and the current capacity of state steering committee members. To complete the system assessment, members of the committee were interviewed. Findings from the dual-purpose assessment helped to inform capacity building efforts with the committee, as well as state plan development. Capacity building with the steering committee focused primarily on "learning by doing," but additional trainings were also provided to committee members. The state Project Coordinator and evaluator anticipate continuing capacity development among steering committee members for IPV primary prevention. As the work of the committee continues, capacity of steering committee members will be assessed and the findings used to continually improve planning, implementation and evaluation processes.

Consideration of Social Determinants of Health in IPV and SV Primary Prevention

Across the two programs, grantees demonstrated an understanding of considerations related to social determinants of health in efforts to prevent IPV and SV and incorporated these into their plans. Each of the DELTA and EMPOWER grantees addressed social determinants of health, health disparities, social justice or intersectionality in their plan development. The consideration of such issues is important because both IPV and SV have disproportionate impacts on certain segments of the population, and some socio-economic issues, such as poverty, are among the risk factors for IPV and SV. The attention to social determinants is reflected in different ways across the plans, including examples such as the development of state demographic profiles, data collection and analysis for incidence and prevalence, the identification of selected populations, prioritization of plans goals and outcomes, adaptations of programming or plan elements, and planning team membership. Attention to such issues by grantees was particularly supported by the Empowerment Evaluation framework that was provided by CDC to grantees for planning efforts, which emphasized public health principles such as social justice, community knowledge, inclusiveness and accountability. The consideration of issues such as social determinants of health and intersectionality when developing primary prevention plans has led to plans that acknowledge and plan for the different needs of various groups within each state.

Montana DELTA Program

Native American women report significantly higher rates of SV and IPV than do women of other racial backgrounds. Seven recognized tribes are located in Montana, representing 60,000 individuals within a state with a population of less than one million people. Thus, attention to tribal populations constituted a significant and consistent consideration in the Montana planning process. The state steering committee used an evaluative tool during each phase of the planning process, designed to ensure that issues related to oppression, diversity and cultural relevancy were incorporated into plan development. The evaluative tool asked a number of key ethical questions and was used to ensure all plan elements met certain basic criteria. One example question was "Does it adequately address the impact of multiple discriminations on individuals and groups in our state (gender, ethnicity, age, able-ism, etc.)?" Plan elements reflect success in this area. For example, the Montana state plan includes the following goal: "By 2015, Montanans will have a better understanding of the impact of intimate partner and sexual violence – as well as equity and respect issues – among and between ethnic and racial groups (primarily Native Americans) in Montana." Other goals, around youth and healthy relationship development, for example, include specific provisions related to cultural relevancy. The development of the "ethical screening" tool not only supported the work of Montana's state steering committee, but was also borrowed by other states, such as North Carolina, seeking to incorporate issues of intersectionality in their planning processes.

•Colorado EMPOWER Program

While sexual violence crosses all socio-economic and cultural boundaries, communities of color often experience differential rates of victimization. Working from a lens of intersectionality and anti-oppression, the Colorado state prevention team quickly identified a number of historically underserved communities as the focus of their state plan. The state capacity building team was intentional in recruiting prevention team members that represented the diversity of the state, emphasizing historically underserved populations. In the work of the prevention team, a decision was made to prioritize the voices of partners and prevention educators of color. Committee members participated in collecting original data from several communities of color in the state, conducting key informant interviews and focus groups with members of these communities including youth, activists and educators. The new data were used to supplement information from the published literature and archival data. Throughout the needs and resource assessment and the development of the state profile, information regarding historically underserved populations was highlighted. Risk and protective factors specific to the priority populations were identified. This information, and the expertise of committee members, guided the prevention team in developing a state sexual violence prevention plan that prioritizes prevention initiatives in communities of color and seeks to adapt and implement prevention programming that is culturally relevant.

•Virginia DELTA Program

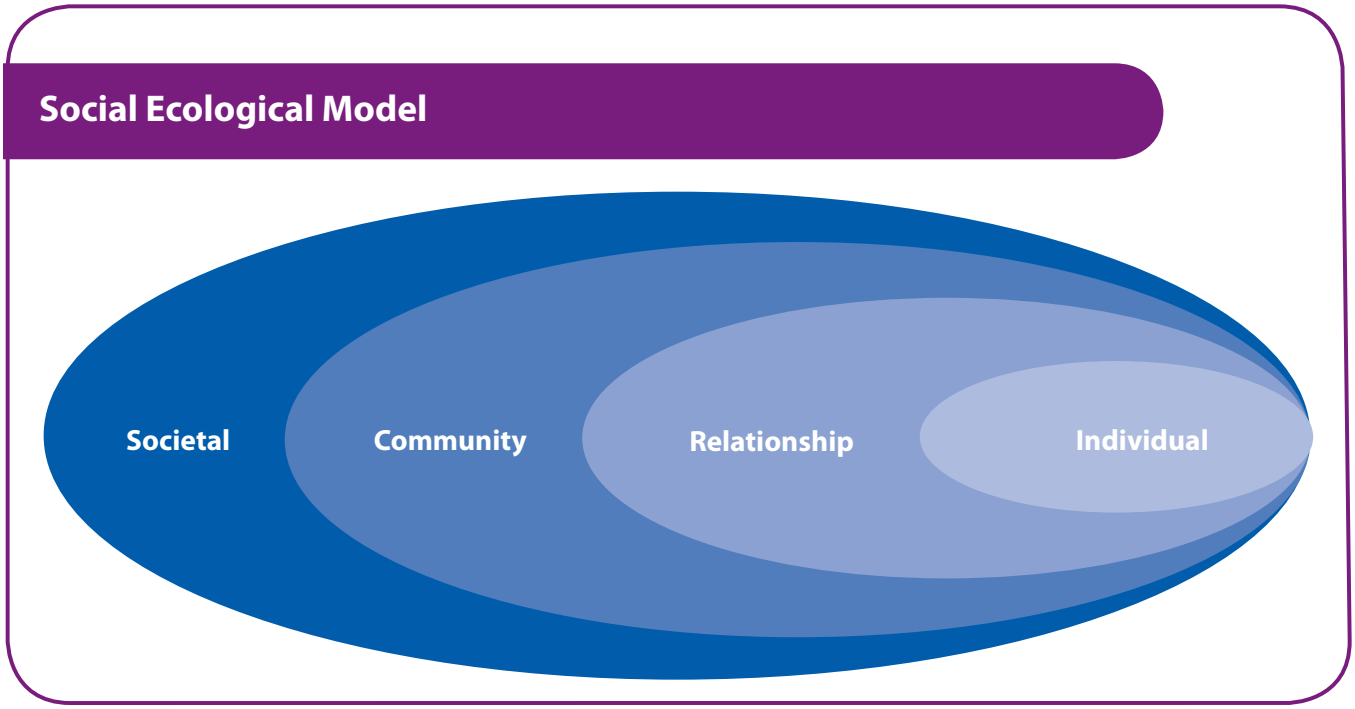
In developing the state plan for IPV prevention, the Virginia state steering committee centralized anti-oppression efforts and sought out ways to highlight the need for attention to these issues. The committee began with the development of a detailed state profile, placing particular attention on disparities (including in such areas as health, education, power and resources) and minority populations. They included data that was difficult to obtain, such as statistics on LGBT populations, inserting "place holders" when the information was not available to draw attention to less visible populations. Their focus on anti-oppression efforts continued through goal and strategy development, including efforts such as increasing the number and diversity of communities in Virginia engaging in effective programs that promote healthy relationships, increasing economic equity for women in Virginia, and increasing the resources available to youth-serving professionals for building healthy relationship skills and positive racial identity for African American youth in pre-K through elementary school.

•North Carolina EMPOWER Program

Persons with disabilities experience sexual violence at a significantly greater rate than that of the general population. With this in mind, the North Carolina EMPOWER Program identified persons with intellectual disabilities (PWID) as one of the selected populations for their state sexual violence prevention plan. As the planning process proceeded, the state prevention team sought to identify strategies and programming to address sexual violence in the selected population. In reviewing existing resources, the prevention team found very few evidence-based models for addressing the prevention of perpetration against PWID. In an attempt to ensure that they utilized strategies most appropriate for the population and with the most promise of success, prevention team members sought the input of members of the PWID community. A survey was drafted for caregivers and professionals. The survey was then reviewed and vetted by a smaller group of individuals affiliated with the PWID community. Data collected through discussions and the survey continue to inform the state prevention team as they work to prevent sexual violence among PWID.

Consideration of Strategies across the Social Ecology

Many of the DELTA and EMPOWER state plans include goals related to implementing strategies at various and multiple levels of the social ecology, seeking to promote the development of comprehensive and synergistic prevention programs. In a number of states, specific prevention strategies that focus on community and societal level change, such as the development of media campaigns to change social norms or educating policymakers about the advantages and disadvantages of public policies and the efficacy and possible ineffectiveness of certain prevention strategies, were identified to complement the work of local communities and leverage resources that local communities do not have. To increase the quality of IPV and/or SV prevention strategies to be implemented, some states promoted specific criteria for prevention programs or particular curricula that align with promising prevention practices. Several state plans include elements for improving the quality of strategy implementation through activities designed to build local or state capacity for IPV and/or SV primary prevention, including training, technical assistance and materials development. Many plans include blueprints for expanding the number of the entities implementing IPV and/or SV prevention strategies in the state, including a specific focus on underserved populations or populations with a greater number of modifiable risk factors.



•Alaska DELTA Program

Alaska's state steering committee sought to increase prevention work for specific populations through a combination of state and local initiatives. At the state level, the Alaska plan includes two population-specific goals. The first, intended to increase youth leadership in primary prevention efforts, includes strategies and activities such as providing youth leadership training events, expanding formal leadership positions for youth, and fostering youth-led prevention initiatives. The second, intended to foster media promotion of healthy relationships and equality, include strategies and activities to improve media coverage and a statewide media campaign geared towards youth. At the local level, the Alaska state plan includes goals and outcomes designed to encourage the adoption of prevention work in each community.

•Florida DELTA Program

Building from the IPV primary prevention efforts of local DELTA communities in Florida, the state steering committee included two goals in their state plan related to addressing the needs of a specific group or population. Specifically, Florida focused on increasing influences on youth to promote healthy relationships. The first goal, building on the literature base regarding youth development and community organizing, seeks to promote youth-driven prevention work through the development of a youth leadership council, increased participation by youth in state prevention summits, and engaging youth in selecting additional prevention strategies. The second goal seeks to promote a modified social norms strategy for youth, with state level activities aimed at identifying sources of youth influence and the development of a social marketing campaign flexible enough for local adaptation to contextual circumstances. Florida's state plan goals related to IPV primary prevention seek to increase prevention work intended to address the needs of a specific group or population while supporting existing efforts of local communities.

Challenges

Each of the DELTA and EMPOWER Program states faced a variety of challenges in developing comprehensive, data-driven IPV prevention plans, many of which have significant implications for future implementation, evaluation and sustainability. Common themes include:

Existing data systems often fail to capture necessary information for effective prevention planning.

In order to maximize limited resources and improve the likelihood of successful primary prevention efforts for SV and IPV, state planning groups required state-specific data regarding the magnitude of the problem and the prevalence of potential risk factors within the state's population. State planning groups were creative and persistent in seeking out archival and published data for planning purposes but were rarely able to find the necessary information. Data that did exist were often subject to many limitations and existing data sources rarely (if ever) use shared definitions, so comparison becomes extremely difficult. In some cases, data that existed could not be broken down by certain subpopulations, making it unhelpful for identifying selected populations. Finally, while much is known in the published literature regarding victims of SV and IPV, much less is known about perpetrators. Planning efforts in every state highlighted the need for improved data systems.

Few evaluated, effective IPV and SV strategies and programs exist.

While DELTA and EMPOWER grantees were tasked with engaging in a data-driven planning process that utilized the best available research evidence to identify strategies, they were hampered in this task due to the fact that few evaluated, effective SV and IPV prevention strategies and programs exist. Several states conducted extensive reviews of existing programs but since no centralized compilation of programs exists, this presented a challenge in itself. Existing programs and strategies also required assessment for fit and capacity for a given state or region. Additionally, many programs labeled as prevention are, in reality, not focused on primary prevention. Often, planning teams expanded their reviews to learn from evidence-based strategies in other fields such as HIV/AIDS prevention, substance abuse prevention, and others. This too presented challenges; however, because states recognized that they had limited capacity to effectively adapt the strategies to the SV and IPV field. State planning committees generally sought to strengthen their strategy and program selections based on theory. While state planning committees did their best to engage in evidence-informed planning, the aforementioned limitations remain a challenge.

Limited financial resources remain a challenge for plan implementation, evaluation and sustainability.

The needs and resource assessments and prevention system capacity assessments conducted during the planning process highlighted a number of areas for improvement and enhancement. These included strengthening prevention system capacity across a number of domains, gaps in SV and IPV prevention programming, and individual and organizational capacity development at state and local levels. Having identified a variety of needs and gaps, state planning committees struggled to balance addressing key areas with developing realistic state SV and IPV prevention plans. Most states specifically identified a lack of financial resources as a barrier to plan implementation, particularly under current economic conditions. For example, while every state identified the need to strengthen existing data systems, few states have identified a source for the financial resources that will be necessary for such a significant undertaking. States also identified significant capacity building needs among local-level implementing organizations for SV and IPV prevention. Current funding for SV and IPV prevention is highly limited, thus, making capacity development initiatives challenging for state health departments, state IPV and SV coalitions, and local organizations tasked with implementation.

Extensive capacity building at the system, organizational and individual levels is required for plan implementation.

While DELTA and EMPOWER grantees have already demonstrated significant gains in knowledge, skills and commitment to data-driven, evidence-based IPV and SV prevention efforts, further capacity development needs were documented in the state plan documents. While most state plans included some provisions for capacity development, capacity development itself presents many challenges. For example, developing the knowledge and skills among individual prevention practitioners will require significant investment over time in the creation and maintenance of a skilled workforce for SV and IPV prevention. Additionally, many states have noted a high degree of turnover among staff members responsible for implementing local SV and IPV prevention programming. Addressing these issues will require changes in not only individual practitioners, but also the organizations they work for, the prevention system, state health departments, and the state IPV and SV coalitions, and how they address capacity development. Capacity building, while essential to effective SV and IPV primary prevention, will require significant time, energy and resources.

Maintaining engagement during a lengthy and complex planning process requires significant process expertise.

Several of the state plans document the challenges associated with maintaining planning committee engagement during the course of a multi-year complex planning process. In some cases, the tasks involved in conducting the planning exceeded the perceived skills and knowledge of planning committee members,

resulting in disengagement from the process. In other cases, the length of the process and the time requirements created barriers for the continued involvement of planning committee members. State capacity building teams employed a number of approaches and adaptations to help in addressing these concerns, but planning committee member turnover remained a consistent concern. States, with the assistance of their Empowerment Evaluators, attempted to design planning processes to address these issues, with varying degrees of success. Some states adopted an approach in which a core group of individuals carried out many of the more intensive aspects of the planning process and involved the larger planning group at key points. Because these core groups (frequently made up of a state-level program coordinator, evaluators and other individuals) often lacked resources as well, this approach carried additional challenges. In other states, state capacity building teams focused primarily on accomplishing planning tasks over process, making participation of planning committee members less of a priority. In most cases, the state capacity building teams had little background in process design, creating another area for skill development in the midst of an already-complex undertaking.

Challenges

Primary prevention of IPV and SV will require individual, organizational, system and social change. Essential to fostering and sustaining IPV and SV primary prevention is the development of increased capacity for primary prevention planning, implementation and evaluation. While the scope of this document is limited, a review of the state plan documents produced by participants in the DELTA and EMPOWER Programs suggests substantial changes occurred in capacity and support for data-driven, evidence-based planning and implementation. Evident in a review of the plans is the level of concerted efforts by DELTA and EMPOWER grantees toward increasing knowledge regarding both effective IPV and SV primary prevention and capacity building, and a demonstrated ability to work with others to achieve better outcomes and maximize resources. Successes and challenges identified can serve as lessons learned for injury and violence prevention programs at health departments and SDVCS as they support and enhance IPV and SV violence prevention efforts in their states.

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